



State of Missouri
Department of Mental Health
Division of Developmental Disabilities
Provider and Services Choice Form for Northwest Missouri Autism Project Services

Individual Name	Date of Birth
Medicaid Number	DMH ID Number

Attach this to the Individual Plan of Care (IPC) – Autism Project Services authorization form.

Individual/Parent/Guardian/Designated Representative Certification and Signature(s) Section	
<ol style="list-style-type: none">1. I certify that I have chosen the provider(s) and service(s) on the attached IPC – Autism Project Services form.2. I certify that I have been afforded the opportunity to select from the list of services and willing and qualified services providers.3. I certify that I have been informed that enrollment in a Medicaid Waiver prohibits receiving services from the Northwest Missouri Autism Project.	
Individual	Date
Parent/Guardian/Designated Representative	Date
Name of Person to be Contacted by Provider	Phone

Support Coordinator Certification and Signature Section	
<ol style="list-style-type: none">1. I certify that the individual/parent/guardian/designated representative has chosen the provider(s) and service(s) on the attached IPC – Autism Project Services authorization form.2. I certify that the individual/parent/guardian/designated representative has been afforded the opportunity to select from the list of services and willing and qualified services providers.3. I certify that I have informed the individual/parent/guardian/designated representative that enrollment in a Medicaid Waiver prohibits receiving services from the Northwest Missouri Autism Project.	
Name of Support Coordinator (please print name legibly):	
Email	Phone
Support Coordinator Signature	Date